Submission
No 109

THE MANAGEMENT AND OPERATIONS OF THE NSW AMBULANCE SERVICE

Name: Suppressed

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Partially Confidential

24 June 2008

The Hon. Robyn Parker MLC

Dear Ms Parker,

Subject: **Upper House Inquiry into Ambulance Management, 2008**

Thank you for the opportunity to contribute to the Parliamentary Inquiry into Ambulance management and operations. Attached is my submission, which deals with the following issues. They are not listed in any particular order of priority but all relate to the management and operations of the Ambulance Service of NSW.

1. **Corporate Culture**
   Poor morale, "management by Union", and the need for a uniformed, Ambulance-experienced figurehead
2. **Bullying and Harassment**
   This is not rife within the ASNSW but is a problem in some areas
3. **Professional Standards and Conduct Unit**
   This unit is seen as existing only to protect senior management from criticism
4. **Asset Mismanagement**
   Ambulance Properties – selling the farm to pay the mortgage
5. **Other Mismanagement**
   Recruitment and retention, Uniform issues, Vehicles, Patient Transport Service, Media Unit, Death & Disability Award
6. **Skills and Training**
   Training standards have declined and quality of service provision depleted
7. **Ambulance Rescue**
   How Executive-level management has refused to support and promote the State's most cost-effective rescue service
8. **Co-ordination Issues**
   The use of a medical priority despatch system that fails to determine appropriate response priorities resulting in increased suffering and reduced service to the community
9. **Suicide among Ambulance Officers**

I hope that my comments may be useful in informing the members of your team about aspects of Ambulance management that are unlikely to be acknowledged by the ASNSW.

I would be happy to provide further comment or information if desired.

Yours sincerely,

Submission to the Upper House Inquiry into Ambulance Management

June 2008

Abbreviations

A/O	Ambulance Officer
ASNSW	Ambulance Service of New South Wales
D/O	District Officer (also known as Inspector or Assistant Operations Manager)
HSU	Health Services Union
IRC	Industrial Relations Commission
MPDS	Medical Priority Despatch System – a system of prioritizing emergency calls
NSWFB	New South Wales Fire Brigades
PTO	Patient Transport Officer
PTS	Patient Transport Service
SCAT	Special Casualty Access Team
S/O	Station Officer (Station Manager)
SRB	State Rescue Board
VRA	Volunteer Rescue Association

Note re terminology: Although the ASNSW has recently changed the nomenclature for its employees, this submission uses the former terms Ambulance Officer (A/O) and Paramedic to denote the two main clinical levels as it is clearer. The terms 'officers' or 'ambos' are used to describe employees of both levels.

INTRODUCTION

I am extremely proud of the work we do as Ambulance Officers and can confirm that the Ambulance Service is held in high regard by most of the community. Unfortunately, this image is mainly due to the efforts of individual officers who struggle to provide the best service to our patients despite a lack of support from Ambulance Management.

Middle managers, themselves, struggle to cope within budgetary constraints and decisions from above. While the executive level of the Ambulance Service may similarly claim it is restricted by Health Department rulings, I believe there has been a failure at the top level of our service to be clear in reporting Ambulance issues in order to gain the required support from the government.

An enormous number of the Service's achievements (standard of vehicles and equipment, staff numbers, skills, and the continued existence of Ambulance Rescue,) are <u>not</u> due to the proactiveness of Management but have been fought for by ambos, usually through the union.

I believe the Inquiry will find that the ASNSW is a valued and valuable organization but that certain endemic problems within the Service need to be addressed at a high level.

I hope that the Inquiry will find there is a need to view and manage the ASNSW as an emergency service and not as some business unit of the Health Department.

1. CORPORATE CULTURE

1.1. OVERVIEW

The Ambulance Service has a long history of providing a vital community service. For a century, the Service operated effectively with a paramilitary structure. While no organizational model is perfect, there are unquantifiable benefits of the paramilitary structure that have been lost in the steady change to a corporate organization, since the 1990s.

Discipline and respect are no longer a part of our operational effectiveness. We have little respect for those at the policy-making level, partly because few of them have earned our respect by having done what we do, and partly because we are not treated with respect. We are treated as numbers, whose requests for equipment or training standards are seen as inconveniences.

Policies are no longer made with consideration of their impact upon employees. A greater issue, however, is that our policies are no longer made for the benefit of our patients. ASNSW policies and decisions are based upon things like 'fiscal responsibility' rather than 'service to the community'. The NSW Fire Brigades do not operate like this. (see Appendix C).

1.2. CHANGED CULTURE

An Ambulance Board and CEO were reinstated in 1990. The first 5-year "Corporate Plan" appeared in 1997, covering the period to 2002. A series of expensive "Corporate Culture Surveys" since 2001 is evidence of a change. All three surveys resulted in overwhelmingly negative feedback from employees but, rather than learn that the corporate approach is itself flawed, the Service's interpretation of its poor showing was to state that "clearly there is more work to be done"[1]. Employees take this to mean there will be more of the same corporate culture in the years to come.

Over the past decade or so, the ratio of senior positions for uniformed Ambulance Officers to non-uniformed support staff has swung dramatically towards non-uniformed employees, who now hold far more decision-making positions than ever before. With the significant reduction in authority held by career Ambulance Officers, high-level management decisions are now less about benefit to our patients and more about stretching resources as far as possible.

Various bureaucracy-inspired changes have increased fatigue, increased response times (once a key performance indicator, but now rarely mentioned) and probably increased the resignation rate. The corporate approach seems to involve simply introducing a change and then waiting to see if employees object. For this reason, union membership is very high and we often refer to the General Secretary of the Health Services Union as "the ASNSW's de facto CEO".

An example of the corporate approach occurred in 2001 when the Ambulance Service commissioned an "operational review". Although the results of the review by an external company were questionable, and were later discredited[2], the Service introduced and continues to cling to all of the following changes.

- Altered rosters — Forcing some staff onto afternoon shifts and longer dayshifts
- Fluid deployment — Deploying ambulances to uncovered areas, usually at night, affecting fatigue levels

[1] Approximate quotation from Corporate Culture Survey report card, 2007. Document not on hand
[2] Letter HSU to ASNSW, 19-8-2004

- Changes to training — Traditional, thorough, face-to-face teaching was replaced by a system where officers are now personally responsible to collect 'points' for attending external courses, often in their own time
- Skills mix — Depleting 'dedicated' intensive care crews (2 full Paramedics) into crews of 1 intensive care paramedic and 1 ambulance officer.
- Selling 16 Ambulance stations

The union subsequently negotiated more sensible arrangements regarding some of these issues but so much effort was required to resist what were initially quite unworkable proposals that no one had the energy to stop the sale of the stations. That matter is discussed further in Section 4.

Our current corporate culture is also responsible for the following.

- Various attempts to divest the ASNSW of the State's most cost-effective rescue service.
- The introduction of a Medical Priority Dispatch System that relies on information from untrained callers and which frequently allocates the wrong priority. Because the parameters are geared towards downgrading the urgency of as many cases as possible, it is now likely that a frail, elderly person, fallen onto a busy roadway, in the pouring rain, in the middle of winter, with a fractured leg and in extreme pain, will <u>not</u> receive an urgent response as none of those factors will prompt an urgent coding.

These issues are discussed separately in Sections 7 & 8.2.

The Late Eric Marks, former Superintendent of Sydney Division who was understood to have been forced to resign in 2003, reportedly said "Mark my words: there is a lot a grief ahead. They (the corporate types) are pushing to have a third-rate service in a first-world country."

1.3. DENIAL OF THE HEALTH CRISIS

For more than a decade, the ASNSW has quietly accepted the hospital crisis by not insisting that hospitals off-load ambulances immediately. This resulted in off-load times increasing from <20 minutes in the past to the current situation where officers can spend many hours standing beside their patients in a hospital Emergency Department.

For the first   years of my employment, if we took longer than 20 minutes to hand over a patient at a hospital, there would be questions to answer. Now, it can take more than 20 minutes just to be seen by the Triage Nurse, and everyone is surprised if an Ambulance manages to unload a patient in less than an hour!

From the mid-1990s, when hospitals became unable to accept ambulance patients, leading to fewer ambulances available on the street, Ambulance Management's approach was to deny that this had anything to do with declining response performance. The findings of a Staffing Review, conducted by Ambulance Management in conjunction with the union, were ignored and, instead, a lengthy and expensive review was contracted through an overseas company.

Following the review, the Service maintained that multiple recommendations had to be implemented despite none of these addressing the fundamental problem that a significant proportion of our personnel are tied up in 'access block' at hospitals.

Many officers believe the Service's avoidance of the real issue results from the Health Department exercising a level of control over the ASNSW that was never seen when we had a State Superintendent at the helm. After stretching its resources and still finding no improvement in response performance, the Service has, in the past few years, been forced to start pointing to the hospital crisis as a cause of the problem.

1.4. BUMS ON SEATS

There is a focus on simply having 'bums on seats' that pervades our Service's management. While some S/Os try hard to ensure their dedicated Intensive Care Paramedic rosters are filled with Intensive Care Paramedics, Area Managers will usually be quite happy so long as there is a name next to each place on the roster. Union sub branches frequently battle to maintain standards of clinical service to the community – a battle that is often lost. (See further under 6.1 Skills Mix)

A numbers-rather-than-service attitude comes through our Communications Centre. The current and relatively recent approach is to put the greatest effort into having an ambulance tasked to a case as soon as possible but then failing to respond timely or appropriate backup. The ASNSW can then report "improved response times" without mentioning that the 'response' is often a single Rapid Responder, a District Officer, or a Rescue Unit, none of which can transport patients to hospital. These initial response units can spend over an hour at patients' addresses, waiting for an ambulance to become available. Whatever is claimed by the ASNSW about response times belies the fact that patients are now waiting longer than ever to get to definitive care.

Many believe this approach stems from the current corporate nature of our service, in which the ultimate aim seems to be an appearance of maintaining or improving performance without any real interest in what happens to our patients or the staff.

If the Service is prepared to treat its staff this way, then one can only imagine how little it thinks of its customers!

1.5. MORALE

Morale among 'road staff' has never been lower in my years' employment and this is partly due to corporate decision-making and partly due to the simple fact that there are now very few senior positions to which an officer can aspire. In fact, the top job is not even held by a career Ambulance Officer. While I have no personal desire for this position, I, like many others, find it quite embarrassing to attend formal functions where all other paid and volunteer emergency services are represented by a uniformed head but all the ASNSW sends is an unidentifiable man in a suit.

It is of great concern to many staff that the current figurehead of the Ambulance Service is not, and never has been, an Ambulance Officer. While, on some levels, this should not necessarily be a problem, it is widely felt that a bureaucrat does not have sufficient understanding of the true nature of Ambulance work to lead us effectively.

I have worked under previous systems where the State Superintendent was always a uniformed officer with a long Ambulance career. Although ambos are never entirely satisfied with their managers, these uniformed heads had the respect of their staff, partly because of their background but also because their decisions generally seemed appropriate to the work we do.

The corporate culture works in subtle way to exert power over the employees of our service. Middle managers are frequently overruled by the decision-makers, and the executive level of the Service simply doesn't make commitments at all. We can no longer expect that any management

commitments will actually be honoured. Every target not met is glossed over by the CEO whose ability to put a positive spin on every failure rivals that of George Orwell's 'Inner Party' in *1984*.

Officers are no longer allowed to wear name plates to aid communication with patients, clinical badges to signify skills, or any community pin such as Legacy pins, Police Remembrance ribbons or Red Nose Day pins. The excuse for removing all embellishments was occupational safety.

Despite the fact that an Amendment Bill was already before Parliament[3], intended to bring common sense back into OH&S legislation, the Service actually performed a risk assessment on the tiny 'service ribbon' that is issued to long-serving officers. Apparently, this 32mm x 12mm, cloth-covered strip "decreases mobility of an Officer in the operational environment - increased potential of catching on other objects and causing injury to the officer"[4]. Curiously, this risk assessment was dated 12 December, nine days *after* the new policy was released.

The Service admits that there has not been a single instance of any injury to anyone from any type of badge (even the larger, fully metal ones) for as many decades as anyone can remember, yet the CEO persists with the ridiculous insistence that we must be kept safe from attack by our badges.[5]

This enthusiasm to manage a non-existent risk is surprising given the Service's appalling record on OH&S issues. Every station has its list of OH&S problems that took years to fix. The Service is currently in dispute with the HSU because of some minor industrial action that is being taken because the Service has failed, for several years, to provide sufficient portable radios to maintain officer safety.

It is hard not to suspect there are other motives for removing badges. Presentations of a new, Long Service and Good Conduct Medal began only last year. Before 2007 had ended, permission to wear the ribbon of the new award on the daily uniform was removed. This makes a mockery of any suggestion that the Service values the efforts of its staff.

Even the nomenclature the Service uses belittles us. For decades since the term "Ambulance Officer" was introduced, it meant only one thing: a uniformed, professional of the Ambulance Service. From 1976, "Ambulance Paramedic" additionally indicated an ambulance officer of the highest clinical level. Since 10 December 2007, we all are now called "paramedics", with the highest level now called "intensive care paramedic". Unfortunately, "paramedic" is a generic term and also applies to many other companies' employees or volunteers.

As if to remind us of our position in the food chain, all the new uniforms are labelled, front and back, with the single word "Ambulance" regardless of our clinical level, and there is no indication on the uniform of length of Service.

In , I was immensely proud to receive my first 'stripe' on my sleeves to indicate that, at three years' service, I had become a fully trained 'senior' Ambulance Officer. While, at the time, many ambos openly poo-poohed such trappings of a paramilitary past, most long-serving ambos now admit quietly that a sense of pride went with them. We also had more respect for those with more stripes as they had been around and knew what they were doing. At large incidents, uniform embellishments created an immediate hierarchy to assist our operations. An aircraft crash today would see a sea of "Ambulance" labels that would not assist us at all.

[3] 2007 OH&S Act Amendment Bill. Introduced to Parliament on 29 November 2007
[4] Risk Assessment form dated 12 December 2007 – 9 days *after* the new policy commenced!
[5] Letter to HSU, 6-3-2008, to confirm the instruction in the Uniform Policy of 3-12-2007

2. BULLYING AND HARASSMENT

I am not aware of widespread bullying or harassment within the ASNSW but this may be because I have spent the vast majority of my employment in the Sydney area. While I know of a small number of incidents where middle managers have acted in an intimidating manner towards junior employees, most of these are third-hand reports. Most also do not seem to be at the level of the cases reported by Phil Roxburgh.

It might, however, be useful for the Inquiry to note that, from time to time, rumours are heard of bullying and harassment at some rural stations. I imagine that such occurrences are more likely to develop in small communities and may not be peculiar to the ASNSW.

The ASNSW has many good and even some excellent managers; however it also has its fair share of people who should probably not be in a position of authority. It is often mentioned by ambos that "anyone who does the wrong thing gets promoted". There are also examples of junior officers receiving promotions before gaining sufficient experience. It may be that some junior managers use bullying until they learn that one gains more co-operation in an atmosphere of mutual respect.

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I could list several currently serving junior and senior managers who, I believe, often treat their underlings quite poorly. I am uncertain, however, whether this stems from their own attitudes or the constraints that are placed on them from above and the management culture in which they operate.

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The matter of managers who bully their staff may stem from the corporate focus on numbers rather than outcomes. By this, I mean that the 'bean-counters' seem to feel it is more important to have a position filled by anyone than to have it filled by the right person. Officers who have served much longer than I have been heard to say "such-and-such (a promotion) would never have been tolerated when so-and-so ran the Ambulance Service".

To be fair, I would add that I could list more good or even excellent managers in the ASNSW than I could list bad ones.

3. PROFESSIONAL STANDARDS AND CONDUCT UNIT

I have only had a little to do with the PSCU but I share the impression of other ambulance officers that this unit exists mainly to protect the high levels of management from criticism.

[following section omitted by secretariat to protect identity of author, as requested]

I regard this third matter as quite petty but it may be an indication of how the PSCU operates.

4. ASSET MISMANAGEMENT - The Sale Of Ambulance Stations

In 2001-2002, the Ambulance Service sold a total of 16 ambulance stations. While I am not aware of the details of most properties, I do have some knowledge of two examples.

4.1.

[following section omitted by secretariat to protect identity of author, as requested]

My understanding is that the transition from owned to leased properties seemed attractive to management because of some arrangement whereby the NSW Government funds the rental costs separately from the ASNSW budget. To pursue such an arrangement, however, seemed (to most of us, even at the time) to be very short-sighted.

The ASNSW is a government body and I believe its executive has a responsibility to ensure its assets and funds are managed in the best interests of the government and the community. Looking at the big picture, one can see that the actions of the ASNSW executive, in initiating such a sale, will result the NSW Government having to pay rent over 10-20 years yet still having to fund any improvements and maintenance during that period.

These seem likely to consume most or all of the proceeds of the sale.

In 2012 (or 2022), the ASNSW will lose the use of the site as it has already been rezoned for high-density development and the owner will certainly prefer to build units rather than continue a lease to the ASNSW. Instead of owning a property worth perhaps $10 million (in 2012, much more in 2022), the ASNSW/government will own nothing. It will also have to fund a relocation and continue to pay rental or find new funds to purchase another property.

The sale of an asset is understandable if it is replaced with another asset; however it would appear that the ASNSW has simply used the proceeds to pay rent on buildings and vehicles. At best, this seems to be an example of 'selling the farm to pay the mortgage'. At worst, it could be viewed as an example of executives furthering their own careers by ensuring the Service continues to appear to function efficiently while actually running down its intrinsic value.

[following section omitted by secretariat to protect identity of author, as requested]

Ambulance property is discussed further in Appendix C.

5. OTHER MISMANAGEMENT

5.1. RECRUITMENT AND RETENTION

When I joined the NSW Ambulance Service in we felt privileged to be accepted. In those days, and for at least the decade that followed, applicants outnumbered available positions by around ten to one.[6]

This is not to say that the Service did not have its 'dead wood' as some long-serving officers, (employed since pay rates and skills were lower and a job was easier to get) struggled with the new skills, but by pay was comparatively good and the Paramedic system had come into its own as a gold-standard of pre-hospital care.

I had always thought that this popularity would continue, as the ASNSW has indeed maintained an excellent image among the community, however in recent years the Service has struggled to attract sufficient applications. Colleagues who have been seconded to interview panels have stated to me that "we are now interviewing people who would never have reached the interview stage in the past". Other Health careers now pay better than ours does and it has become harder to attract quality applicants. We seem to be collecting more 'dead wood' again.

The ASNSW is currently fighting bitterly to limit a major wage increase claim through the IRC. The Service does not seem interested in allowing the pay rate to become attractive again.

5.2. THE NEW UNIFORM

I am not certain how long ago the ASNSW began looking at a new uniform but I suppose it was in the mid 1990s. To cut a long story short, a uniform committee of ambos and managers spent years developing a 'working uniform'. It is claimed by the Service to be "more comfortable, practicable and ... durable", a uniform "designed by paramedics for paramedics". The ASNSW even blamed the delay on the need to produce the "best possible uniform".[7]

The uniform was never trialled. It was introduced on 10 December 2007 and it was immediately apparent that those claims are false.

1. It is not only less comfortable, it is essentially unwearable in warm weather. Long sleeves are the only option and the material is far thicker (185 grams per sq m) than the committee had agreed (155 g/sq m). The tee-shirt undergarments all arrived with Asian neck-sizes and officers have to break the stitching or re-order a huge size to avoid being strangled.
2. With a strange pocket design, a large and inexplicable flap on the sleeve pocket, nowhere to store a pen, a belt that has to be dismantled to put on, bulky material around the wrists (quickly labelled the "vomit scoop") and the single word "Ambulance" on the back that fails to differentiate between many different skill levels, it is certainly not practical.
3. The uniform is not even durable. After only two months, the reflective lettering had already faded considerably on the majority of uniforms. The manager in charge of the uniform project tried to claim, many times, that the garments had not been cared for properly, despite the fact that no washing instructions were provided.

[6] I have no actual data but it was common knowledge that applicants were in oversupply.

[7] Quotes from ASNSW website, "Uniform Questions and Answers" downloaded 28-1-2008 and 8-6-2008.

The uniform certainly does not create a professional appearance. Basically a two-piece, off-the-rack set of overalls, the Service allows only the pants' legs to be hemmed and no other alterations are permitted (unless the officer has an unusual body shape). Irritating Velcro adjustment tabs on the lower edge of the shirt mean only the most appearance-conscious officers will tuck the shirt in. The Service's uniform policy actually allows the 'overshirt' to be worn untucked and completely unzipped! Photographs on the website and in media releases show the uniform being worn in this untidy manner.

It is hard to imagine a uniform, despite the years it took to create, being *less* like what had originally been intended.

Questions were asked and it came to light that the committee did not contain a single representative of the ambulance officers who work in Sydney, despite Sydney having the largest proportion of the state's staff. Even then, the officers who *were* on the original committee stated that many aspects of the uniform were not what had been agreed.

It seems that the Service had formed a committee only to create the appearance that it had consulted staff, and then largely disregarded that consultation when making decisions.

More than six months after its introduction, the new uniform remains a total embarrassment to the ASNSW. No corrected uniforms have yet been made available to officers, and those who wear the 'working' uniform are all seen with faded lettering.

> On 19 June, a colleague showed me a new Ambulance overshirt that had been in the same wash as four other new shirts. This one had basically lost all its lettering in the first wash. This shirt was issued more than four months after the quality issues were raised.

Many officers still choose to wear the former white shirt and blue trousers, thus the ASNSW currently has no standard "uniform".

No formal uniform

According to the current uniform policy, the most formal outfit that officers can wear to functions is an "operational jacket". The formal tunic was removed with the new policy in December 2007. The fact that almost every one of perhaps 60 to 80 officers went to the recent funeral of a former senior officer wearing their previously-issued formal dress tunics indicates that the ASNSW has overlooked the importance of providing a presentation uniform.

Uniform summary

Ironically, the Service already had a perfectly serviceable 'working uniform' in use. Rescue and SCAT officers wear a uniform in the same colour and very similar style to the new general

uniform, but without the various problems listed above. The specialist uniforms are made from quality material, have robust lettering and many have lasted for a number of years. The irony in attempting to issue cheaper garments to all officers is that the correction of defects and the more rapid replacement that will be required will quite probably result in greater cost than had the Service simply issued a version of the specialist uniform.

Although this issue is not the most serious, nor the most costly, it is possibly one of the most poorly managed projects in the history of the ASNSW. As if to add insult to the discomfort of the uniform, the manager in charge of the uniform project was recently awarded the Ambulance Service Medal for his efforts.

5.3 VEHICLES

In the mid-1990s, the union campaigned heavily for more, desperately needed staff. The government funded additional numbers but Ambulance management never sought to increase the number of ambulance vehicles. More than a decade later, we can still see some officers turn up to work but have no vehicle to use until the previous shift's crew returns after overtime.

Since the 1960s, the Service has used F-series light trucks as ambulances. Around 2000, we were told that F-series vehicles would no longer be available from Ford and so we tolerated a change to leased Mercedes vans. The "Mercs" were accepted because they are actually very well set up in the back, but they have small wheels, low ground clearance and stiff suspension, and provide a rougher trip to hospital than ever before. Essentially, the Mercs are still just parcel vans.

According to the internet, F-series Fords are now the most widely sold vehicle on the entire planet so the information we were given was false.

After experimenting with Taragos and Commodores, the Service also tried to introduce small VW vans as ambulances. This was all about saving money and nothing about patient care, but the VWs did find some acceptance among rural ambos because they actually have a more comfortable ride than the bigger Mercedes. For the high volume of trauma work in Sydney though, the VWs are simply not large enough. After many, many false promises about how "the next model VW will be much bigger", the Service eventually committed, in 2007, to replacing all VWs with Mercedes. Apparently, this will still take several more years to happen.

5.4. PATIENT TRANSPORT SERVICE

One sensible move in the late 1990s was to set up Patient Transport Service within the ASNSW. From 1998, a number of Patient Transport Officers (PTOs) were employed, on an even lower rate of pay, to transport routine patients who do not require active treatment en route. These officers do not attend emergencies and their vehicles and uniforms are somewhat different to ambulance officers', so as not to confuse the public.

Because they do not take patients through Triage in emergency departments, they are rarely delayed in their work. They are highly productive and bring in considerable revenue for the ASNSW. PTOs I have known are generally very motivated, dedicated to their patients, and most of them are keen to progress to A/O and Paramedic levels.

5.4.1. PTS Workload

Despite a gradual expansion of the PTS, there is still far too much work for the PTS to handle on its own. A/Os are therefore often found doing routine work, Paramedics are then doing the A/Os' medical work, while response times to emergency calls deteriorate.

5.4.2. PTS Conditions

It took years of effort by the HSU to gain for PTOs the right to have their 20 minute break at their own station. Last month, the Service attempted to remove this right.

As recently as March 2008, the Service arbitrarily decided to remove one of the few 'day of in lieu' conditions that had been applicable to PTOs. Once again, HSU had to step in to halt this action but the matter is not yet resolved.

It is little wonder that few PTOs wish to remain in that classification for a long time.

5.4.3. PTS Management

Unfortunately, the PTS was very poorly managed from the start. For a number of years, there was no identifiable management structure for PTOs. Initially one, then two Co-ordination Centre officers had the responsibility of managing the entire PTS, however they had little time to do more than co-ordinate rosters. Station Officers who had PTOs at their stations had limited authority to manage PTS issues.

A couple of years ago, a specific PTS Manager position was finally created but, until then, the ASNSW had basically expected that the PTS would run itself without proper management. My impression is that it was known that PTOs would not complain about issues in their job because they do not want to jeopardize their chances of advancement.

5.4.4. PTS Training

After their two-week induction education, the first PTOs had to learn their job as they went along. Even the second and third groups of PTOs were often not partnered with the more experienced PTOs but were paired as new employees and sent out to work without mentors. It is fair to say that this is now much less of an issue.

Traditionally, all (ambulance) officers received recertification training every two years. It was only in 2007/8 that PTOs finally started to be put through two days of in-service training, almost ten years after some had been employed.

5.4.5. PTOs' Opportunity for Advancement

PTOs have long been frustrated by their limited opportunity to progress to A/O levels. Although the first intake was told they would progress automatically to A/O level, they soon found that they had to apply for A/O positions alongside members of the public. It was fairly obvious that the Service did not favour PTOs becoming A/Os because that would mean a PTS position would have to be backfilled, necessitating another recruitment process.

After long representations by the HSU, there are now separate intakes for PTOs to apply for A/O positions, but automatic career progression still does not exist and some frustrated PTOs have left the ASNSW to pursue ambulance careers in other states.

The ASNSW would no doubt seek credit for its recent improvements in PTS training and management, however it important to note that these things should have been in place at the time the PTS was implemented.

5.4.6. PTS Recommendations

- The PTS should be expanded to be able to meet the demand in routine work
- The ASNSW should either facilitate progression from PTO to A/O or make the PTS attractive as a long term career option
- The limited PTO numbers on Saturdays should be increased, especially during the annual winter hospital bed shortage

- PTS rosters should include some Sunday coverage

5.5. AMBULANCE MEDIA UNIT

The Public Affairs Unit for the entire ASNSW occupies one small room at State Headquarters, Rozelle. There is a Director of Public Affairs who sits at executive level but the unit itself is managed by one civilian Manager, one 'writer' and just two seconded ambos. They use a rotating day/afternoon roster so, at most, there would only be two on at any one time. This is hardly sufficient to promote what is effectively the world's largest ambulance service.

There is a high turnover of the seconded ambos because they have to work so hard to deal with so many issues. They are on call to deal with overnight issues but get no overtime if called out. They are basically unable to work on any proactive promotional campaigns because all their time is taken up with radio reports, major press releases and ensuring the ASNSW does not inadvertently mention the Health crisis.

Local police and fire stations get their activities in local papers every week. Ambos do not get time to publicize their huge workload and our Media Unit does not have the capacity to report local matters to local papers.

In one sense, the Media Unit is managed extremely 'well', if protecting the Health Department from criticism is considered a good thing. Whether the extreme under-resourcing of this unit is deliberate or negligent, it squanders a golden opportunity to promote what should be the world's greatest ambulance service.

> In December 2003, Ambulance Officer Terry Carr, of Avalon Station, was first to arrive at the terrible scene on the Northern Beaches where a car had crashed into a kindergarten and caught fire. He and bystanders rolled a burning car over and rescued Sophie Delizio and another child from the flames before any fire-fighters had arrived. Other ambos treated another 6-8 injured children.
>
> It took two years before the ASNSW finally awarded him a certificate of commendation for his actions and there was one small article in a local newspaper.
>
> The Fire Brigades, however, had their fire-fighters on the television the very next night, and said they would be awarded bravery commendations. Today, the public has no idea that the fire-fighters were *not even involved* in the rescue!!! A colleague told me that a fire-fighter mate of his got a commendation despite only having been on the sidelines.
>
> Google 'Sophie Delizio' and you will find a SMH article that still states "Firefighters and bystanders rescued Sophie"!
>
> Similarly, just a few years ago, SCAT Paramedic, Paul Kernick, performed an extremely technically difficult rescue of a base-jumper at Pearces Pass in the Blue Mountains. This job took many hours as he undertook a huge abseil and then had to traverse, horizontally, the face of the massive cliff, repositioning his anchors as he went. He had to assess and stabilize the patient, with a fractured leg, who was on a tiny ledge, hundreds of metres above the valley floor. After managing to catch the winch line from the helicopter that was forcing 5 tonnes of downdraft onto them, he secured the patient to the line. I think he may even have had to prusik back up the way he had come, to get himself to safety.
>
> The ASNSW no doubt got some credit as the incident was shown on Channel 7 news, that night, but no song & dance was made of the ambo who did the hard work. It was not until this year that he was awarded a "certificate" for his efforts.

5.5.1. Ambulance Media Recommendations:

- The Media Unit should be expanded greatly to allow
  - more effective promotion of the ASNSW
  - more involvement in public education
  - media officers to attend local stations for news stories
- Ambulance Media should be allowed to admit when ambulances are delayed at hospitals

5.6. DEATH AND DISABILITY AWARD

After ambos pushed to be given the same Death and Disability cover as was awarded to police and firefighters in 2003, the Service and HSU negotiated on the model of insurance cover that took effect on 30 November 2006. It was not until late 2007 that deductions started to be taken from officers' pay.

Since the Service had never communicated any detail of the scheme to its staff, the sudden deductions caused much confusion and anger. The deductions are supposed to be calculated on an employee's "base rate plus 20%", which does not change from pay to pay. Many officers are reporting that the amounts deducted vary wildly from pay to pay. The pay office has acknowledged that "some" amounts have fluctuated and it has promised to do better.

The required Product Disclosure Statement (drawn up by the insurance provider, First State Super) was not published until April 2008 I have not yet received the PDS on a scheme I have been paying into for over six months.

Although the scheme was desired and requested by ambos, the whole thing has been very poorly managed by the ASNSW.

6. SKILLS AND TRAINING

6.1. SKILLS MIX

From the early days of intensive care Paramedics in the mid-1970s, it was recognized that having two highly trained officers working together is the best way to deliver the highest standard of care. It is not simply that two people can apply numerous advanced procedures more quickly in situations such as cardiac arrest, there is also great pressure to remember many protocols, calculate drug doses and co-ordinate resources rapidly in uncontrolled and highly stressful situations. The burden of this responsibility is lessened when shared with a clinical equal. The double paramedic team is still the international "gold standard" of pre-hospital care.

For over 20 years, the ASNSW operated a two-tier system where Primary Care A/Os attended all manner of cases while Paramedics were targeted at the more serious cases or sent to backup other A/Os. I believe that the Paramedics comprised about 10% of the Service.

From the mid-1980s, the Service made commendable advances in increasing the skills of A/Os and introducing an intermediate level of training. The new Advanced Life Support officers were given an allowance for their skills, though it was naturally less than the Paramedic allowance. By the early 1990s, the ASNSW had a system of 5 clinical levels operating effectively. In 1998, the ASNSW added the PTS tier to handle much of the routine work.

It was assumed that increasing the general skill level would reduce the need for fully qualified Paramedics. It was also a consideration that strategically located Paramedics meant the majority of stations, and therefore the majority of suburbs, did not have Paramedics actually based there.

From its 2001 Operational Review, the Service proposed "skills mix" – spreading the Paramedics around by crewing each full Paramedic with a junior officer. We were assured that cases such as cardiac arrests would still get two Paramedics attending because two crews would be responded and each would include a Paramedic. While this sounds a nice concept model to put to government, it necessarily included the need to deploy the new skills-mixed crews to all manner of calls and not just the ones that needed their skills. This meant that, today, much of the time, our most skilled officers are found standing in the queue at Triage, tending the minor ailment that they had brought in two hours earlier.

Some managers did see the sense in maintaining dedicated Paramedic units and the Service agreed to maintain dual-Paramedic rosters in their traditional locations, though mostly for political reasons. These were labelled "Centres of Excellence" and were to be places where new Paramedics could be rostered with experienced officers for their training period.

Unfortunately, this commitment meant little in reality.

There is nothing unusual about this roster period. It is typical of a "Centre of Excellence" in today's ASNSW. While the Service will still send two crews to a cardiac arrest, today it is more likely that only one of the four officers will be a fully qualified Intensive Care Paramedic.

Perhaps because the community is largely unaware of this change and there has therefore been no outcry, the ASNSW recently documented its plan to remove dual Paramedic crews altogether.[8] It proposes to have just one "Intensive Care Paramedic enabled" car (meaning just one fully qualified Paramedic on board) for every three stations (about 5 operating ambulances). In other words, the number of Paramedics will be reduced to the 10% it was in the past. The difference, however, is that those few Paramedics will now be tied up doing ordinary medical work.

6.2. RAPID RESPONSE

Rapid Responders are single officers who respond to calls in a vehicle that is not an ambulance. The idea is that they can reach the scene more quickly and commence treatment while a transport ambulance is on its way. The concept of rapid responders actually dates back to the mid 1980s when two forms of single officer response were instigated.

1. Motorcycle Paramedics were utilized in the CBD, for greater mobility around traffic. These continue to operate today, and very successfully, but still only in the CBD.
2. Clinical Supervisors were Paramedic Station Officers who travelled in ASNSW cars to assist other officers at serious incidents. They also gave Probationary A/Os invaluable experience through several 'ride alongs' during each new officer's training period. This excellent approach lasted only a few years before formal clinical supervision was dropped.

Having Rapid Responders in cars was piloted in 2003 and they are now part of the ASNSW's approach to addressing response times. Two points are important to note.

1. The ASNSW has always wanted to deplete rosters of paired Paramedics to support Rapid Response rosters. In other words, the ASNSW would prefer to have 2 officers in two vehicles, not one. The HSU had to fight to keep rapid responders as additional to rostered levels, so that the number of available ambulances is not reduced further.
2. Rapid Responders are probably effective in reducing the time it takes to get a (one) Paramedic to an address but there is then much less pressure on Co-ordinators to find an ambulance to provide the transport to hospital.

"Response Time" traditionally meant the time it took to get an *ambulance* to a patient. That ambulance would be capable of taking the patient to hospital, urgently if necessary.

"Response Time" now refers to the time it takes to get *any* officer to the scene, even if it is by car or bike with no capacity to transport even when necessary.

The current rapid response system is, itself, somewhat counter-productive. Even before the responder determines that the backup ambulance is not required urgently (as is common), the Co-ordination Centre often sends the ambulance to another call. The responder is then stuck at the address, looking after the patient, who still has to be transported when an ambulance becomes available. The whole case-cycle time, from call to off-load at hospital, may now be three or four times longer than if a transport-capable ambulance had been sent in the first place.

Any benefit from having rapid responders is off-set by the fact that this approach actually slows down the whole Ambulance system. Our Computer Aided Despatch system would have the capability to collect data on case-cycle times but they are never reported by management.

The fact that rapid response is focussed on stretching resources rather than providing quality care is evidenced by the latest internal advertisement for those interested in performing this role.

[8] Minutes of Sydney Joint Consultative meeting between ASNSW and HSU 5-6-08

Instead of fully qualified (Level 5) Paramedics, the minimum clinical skill level has been dropped to P1[9], which is different to but slightly below the old Level 4.

6.3. TRAINING AND THE 'CERTIFICATE TO PRACTICE'

Since the 1970s, Ambulance training consisted of face-to-face teaching and on-the-job training. Every two years, all officers attended refresher and updated training. 'Recertifications' included a week of classroom instruction, practical assessments and a theory examination. The great benefit of this system was that every officer, from Sydney to Broken Hill, received exactly the same training, relative to their level.

The desire to stretch resources further, however, led the Service, around 2003, to propose a system where officers would be given credit for external courses or study that they do in their own time, thus reducing the need to take them 'off the road' for formal training. While this concept has merit, particularly for rural areas where some A/Os have more time to study, and where travel to regional training centres is less convenient, this approach was not simply added as an option but was introduced as a replacement to the traditional recertification method.

Called Certificate to Practice or "CTP", it involved crediting officers with a certain number of points for undertaking various education-related activities. In order to make the change appealing, points are awarded for a huge range of activities, not directly related to training, such as periods acting as a Station Officer. The 'carrot' that was dangled in front of officers was that, while they would still have to be assessed in some basic skills, they would not have to undertake the written exam every two years.

Initially, CTP was proposed as one of two options but it soon became almost mandatory. The ASNSW and the HSU produced a joint statement, in December 2004, that CTP would only become the sole training process once a series of support mechanisms had been put in place. These included extra training officers and, most importantly, additional rostered staff (the 'relief component') that would allow officers to have two days of study leave per year to attend courses and seminars.

CTP was supposed to be fully implemented by 1 January 2007 but, more than a year later, this still has not happened. That vast majority of A/Os who were lured or forced onto CTP now find it virtually impossible to get any study leave and also carry personal responsibility for collecting sufficient points to complete the required training.

Instead of a system where officers were given the training required to perform their job, we now see employees having to spend money to attend courses and seminars, in their own time, simply to maintain their work-qualifications. None of this money and very little of this time is ever reimbursed by the ASNSW.

The Service no doubt recognizes that it has created a problem by not ensuring support systems were properly in place before embarking on such a major change. It is now in the IRC arguing that it should lengthen the CTP period from 2 years to 3 years. This is mainly because three years since the last cycle have already passed yet few officers have been provided the CTP workshops for their practical assessments.

[9] Expression of Interest 21.08, e-mailed to all officers on Monday 16-6-08

6.3.1. Responsibility for Education

In past years, any changes to procedures would be explained to us at our second-yearly recertification courses. This method was still in place at least until the late 1990s.

These days, we get an entire rewrite of protocols sent to us in the internal mail, as often as twice per year. There are explanatory notes accompanying the protocols but, these days, it is entirely our responsibility to learn and interpret the changes. If any ambo has difficulty understanding any of the material, then it is up to the individual to contact an eductor to provide assistance.

Much of our other education material also arrives by the courier. We have disks on Meningococcal Disease, Mental Health and other topics and it is up to us to learn about these issues in whatever downtime we get on shift – or study at home in our own time. I have in my locker no less than 7 bundles of Protocol amendments that have been distributed since 2005. I have received not one training or information session to educate me about the changes.

The ASNSW probably congratulates itself for the reduced cost of education but there is no quality assurance in this approach and I have watched ambos take shortcuts to complete various distance learning packages.

6.4. QUALITY OF TRAINING

In the 1980s, ambos had to cannulate 50 patients in hospitals before being allowed to cannulate 'on the road'. Today, an ambo is regarded as competent in this skill after just 5 successful attempts.

7. AMBULANCE RESCUE

Since 1941, when Ambulance Officers and Police combined resources to perform a vertical recovery of a body at The Gap, the ASNSW has been at the forefront of rescue in NSW. Borne of necessity from an increasing number victims trapped in car accidents, the Ambulance Service created the very first dedicated Rescue Unit in 1961. This unit received international praise in a SMH article in 1964 (see Attachment B).

The "safe removal of trapped persons from actual or threatened danger of physical harm"[10] is fundamentally what Ambulance Officers do. Quite apart from car accidents, every day of their careers, ambos work out how to get frail, elderly, ill, injured and/or obese patients out of their bedrooms, down (or up) staircases that they have not climbed since they could walk, and out of their buildings. Every rescue of a person requires an ambo there to provide medical care. Almost every rescue is a delicate operation where solid material has to be manipulated away from flesh. Rescue is not about cutting up cars – it is about untrapping a person.

The rescue of trapped persons goes hand-in-hand with pre-hospital care and this was well understood by our managers of the past and by other agencies. Police and Ambulance Rescue frequently worked together to release persons trapped in vehicles, machinery or on cliffs. Firefighters of the past performed some rescues with what limited equipment fire appliances had.

In 1989, however, the State Emergency and Rescue Management Act divided the State into geographical rescue areas and brought the NSWFB into the system as an official rescue agency. Despite this, Ambulance and Police continued operating rescue units in high rescue-workload areas.

By 1995/6, under State Superintendent McLachlan, Ambulance Rescue was still at the forefront of rescue with the acquisition of state-of-the-art rescue trucks that could even transport patients. Unfortunately, Supt McLachlan was forced to resign in 1999 and I believe it was then that the CEO became the controlling position in the ASNSW executive. Rescue did not seem to have a place in the 'corporate' Ambulance Service and our training became neglected and our rescue management was stifled in every advancement it tried to make. We saw a series of rescue superintendents resign out of sheer frustration.

By early 2001, we had a rescue manager in name only, no spare rescue vehicle in the whole state and training was continuing only through the sheer dedication of the officers on each rescue station. Rosters had become depleted and, at one point, just 68 Ambulance Rescue Officers were working around the clock to cover rosters that would normally have required over 100 personnel to staff.

We took some comfort when the 2001 *Code of Conduct* appeared. In its preamble, the CEO gave his "personal commitment to (among other things) rescue…". We were not to know that three months later, he and the Ambulance Board would decide to "divest the Ambulance Service of its rescue role". An immediate campaign was started to save Ambulance Rescue. With wonderful support from the public (21,000 signatures on a petition), the media and members of Parliament, the State Rescue Board decided it was not in the community's interest for the ASNSW to divest itself of rescue and some appropriate funding was provided by the government.

Since 2003, Ambulance Rescue has gone from strength to strength. Through the wisdom, dedication and sheer persistence of the current Rescue and SCAT Manager, Keith Williams, we now have every element of training thoroughly documented and applied according to national

[10] Definition of Rescue per State Rescue Policy

training standards. We have new equipment, new rescue trucks and about 200 Ambulance Rescue Operators all competent in the full range of general land and vertical rescue procedures. I can say with all honesty that I believe Ambulance Rescue to be second-to-none.

Not only rescue training but also equipment maintenance and rescue vehicle servicing are all managed seamlessly by our Rescue section and this must be the greatest example in the whole of the ASNSW of something actually being well-managed.

The Inquiry should know, however, that this current situation is not due to any great support from the executive of the ASNSW. The following is evidence of this lack of support.

1. Even after Ambulance Rescue was 'saved' by the SRB in 2001, the ASNSW did little to support it. By the time our current manager applied for the job in 2003/4, the position was still merely a 'secondment' because the ASNSW still had no official position for a manager of Ambulance Rescue. He was not permanently appointed until last year.

2. Legislation requires that each rescue agency is represented on the State Rescue Board by the head of the organization or his/her delegate. Our head is the CEO but he rarely delegates this position to someone with rescue knowledge. There would be no problem with this approach except that the CEO does not appear to consult with the rescue manager and therefore makes all decisions affecting rescue in isolation.

3. I am aware of several opportunities for expansion that have been proposed (for instance when the Volunteer Rescue Association was no longer able to provide rescue services in Penrith in 2006) but every one of these was blocked at executive level within the ASNSW.

4. In 2006/7, the latest in specialist heavy rescue vehicles came on line for Ambulance Rescue. Early photographs show the first truck signwritten with the words "Heavy Rescue", as these trucks' equipment matches the capability of any agency set up for the biggest rescue situations.

5. Several decisions have been made by the SRB that would not be supported by the data that have been collated by our rescue office, yet every SRB decision is documented as being "unanimous", indicating that our CEO has either failed to promote his own rescue service or has actively voted against it. The latest of these is a decision by the SRB to allow the accreditation of several additional NSWFB rescue units in the Hunter, Illawarra and Central Coast, in May this year. The recommendation came from the NSWFB, based on its interpretation of a report that used assumptions and normal driving speeds to estimate emergency response times. The ASNSW has at least 2 databases that can provide actual response times to the areas in question however our CEO refused to take this data to the SRB meetings and then voted ("unanimously") to support the NSWFB proposals. The HSU protested to the Ministers and the Premier but they probably felt obliged to accept the recommendation of the SRB.

As if to add insult to injury, the ASNSW website, from 8 June, this year, now proudly displays the headline "Minister Announces New Rescue Units" but the three attached press releases merely explain how the Ambulance Service has *lost* some of its rescue area to the NSWFB.

8. AMBULANCE CO-ORDINATION

8.1. Radio Communications

In 1939, Central District Ambulance became the first ambulance service in the world to use radio communications. During the early part of my career, we still used voice communications via a fairly robust VHF network. During the 1990s, we moved to a system where much information is transmitted to a Mobile Data Terminal (MDT) and, at some stage, we were included in the Government Radio Network (GRN).

When the MDTs were first installed, we were told that we would no longer have to radio any standard messages by voice so the first radios transmitted both voice messages and data on the one system. The fact that some messages still had to be spoken meant that the system was initially very slow. Also, as soon as we stopped hearing the calls that were previously audible to all ambulances in a radio channel's area, we lost the ability to make suggestions when the co-ordinator forgot that a certain crew was in a particular area. We soon found ourselves often passing other ambulances, doing emergency runs in the opposite direction!

Since co-ordinators have many things to think about, they often make mistakes. Even with today's Computer Aided Despatch (CAD) system, errors still seem to occur. The only way to overcome that was to have the crews repeat back to the co-ordination centre, by voice, all cases received. It's now virtually the same as it was years ago, though we do now have a screen with some additional details displayed for reference.

Neither the early MDT nor the CAD systems had ever really been used by a time-critical service the size of ours, and so there were many technical inadequacies. Although most of these have now been overcome, they both required several very expensive upgrades.

Ultimately, after all that cost, my uneducated observation is that the modern system is no less or more effective than the one we used 20 years ago.

Of course, the CAD does allow for the collection of a great deal of data on response times but these have only deteriorated so the Service simply avoids reporting them.

8.2 Co-ordinators

Probably from as early as 1939, "Controllers" were always ambos who chose to move into the radio room as a career option. They would rotate between co-ordination work and 'on the road' work, every few months. This meant they were intimately acquainted with our work. They knew which streets were steep or narrow, and which hospitals are like rabbit warrens and take ages to walk to certain wards. As 'one of us' there was a greater degree of co-operation between ambos and co-ordinators than exists today.

Today, the CAD is presumably supposed to do so much of the decision making that the Service has moved towards having more civilians as co-ordinators. These people tend to make far more questionable decisions yet some react defensively if a crew should dare to offer a suggestion. Unlike the Police co-ordination system, which announces the calls and asks for "any car in the vicinity" to respond, the ASNSW depends largely upon the computer to choose who responds.

A 'them and us' culture has developed and, although we always respond to the jobs we are given, we often just shake our heads if we know that a different co-ordinator would have made a better choice. This is one of the frustrations of ambulance work.

I must qualify these comments by adding that even some of the co-ordinators who *are* ambos are not the best co-ordinators.

There is also one we call the "Fluid Deployment King". 'Fluid deployment' means moving ambulances into areas that have less cover. This fellow feels obliged to keep all his ambulances moving about like chess pieces as he attempts to position crews exactly halfway between other available crews, day or night.

Unfortunately, while the concept of fluid deployment sounds like a neat idea, my experience is that, more often than not, as soon as we move towards an 'uncovered' area, we get an emergency call back to the area from which we just came! I am convinced that fluid deployment does nothing more than waste fuel and add to fatigue. Even most co-ordinators don't bother with fluid deployment as often as they did when it first started.

The ASNSW has never published any data on the effectiveness of fluid deployment.

8.3. MEDICAL PRIORITY DESPATCH SYSTEM

Historically, ambulances always responded urgently to all calls from members of the public. While not ideal, this approach ensured that no injured or ill person was left suffering while waiting for an ambulance.

In 2005, the Service started using an "immediate but not urgent" response for certain calls. "R2" means responding without lights or siren and obeying all traffic rules. The level of urgency allocated to a call is determined by the caller's responses to a series of pre-set questions.

Unfortunately, this system has two major flaws.

1. **It relies entirely upon information from an unreliable source**. Bystanders are generally untrained and, if the patient is the caller, any confusion will provide the wrong answer.

2. **It is geared towards downgrading as many jobs as possible**. Initially, the Service estimated that 60% of public calls would now be non-urgent. I would estimate that that figure turned out to be correct.

The dangers of these flaws should be obvious but below are some examples of where the system failed to allocate an R1 coding to cases that warranted an urgent response.

[following 2 pages omitted by secretariat to protect identity of author, as requested]

There are many more cases where it would have been 'nice' to see an ambulance attend more quickly but reported the more obvious MPDS failures to the Service. Even then, the vast majority of reports were met with the reply that "the call was coded correctly based upon the information available to the call-taker". In other words, 'we did nothing wrong because the caller didn't tell us exactly how crook the patient was'. This is ludicrous! Our system relies upon medical information from callers with no medical training at all.

Most ambos do not get time to complete feedback forms. The list above is therefore the tip of the iceberg.

Even worse, many ambos did provide feedback in the early months but the standard response I quoted above quickly put them off bothering to give feedback. In about 2006, the ASNSW stated in the IRC that "the MPDS is clearly working because we are receiving fewer feedback forms."

One can understand why fewer forms are sent when the replies from the Service include wording like "Staff need to understand that prioritization of incidents using the MPDS system is largely dependant upon reliable information from the caller." Well, *that* was the problem we were trying to point out to the Service!

As you can see from the list, given up bothering to send feedback.

The primary excuse given for adopting the MPDS was to "improve...safety through reduced lights and sirens response". It is significant that no data were ever produced to support that reason. The fact is that the number of ambulance collisions was always very low in NSW and probably hasn't changed despite MPDS being introduced.

Most of us believe the real reason for downgrading responses was simply to reduce the number of calls that would be subject to scrutiny, thereby hoping to improve response times to the more limited number of 'urgent' calls. Naturally, this cannot happen because the more responses are 'non-urgent' the slower the entire system becomes, as outlined in 6.2 *Rapid Response*.

As recently as 5 June 2008, the Service announced at a meeting that further changes to the MPDS would "result in a change to mainly cold (non-urgent) responses". Further, it will remove "the requirement for immediate activation" and calls will "be referred to secondary triage and a response will not be generated until after completion of secondary interrogation".[11] In other words, calls will take much longer to process before a response code is allocated, the ambulance may not be despatched immediately and, even then, the response is likely to be at normal traffic speed.

By comparison, the NSWFB always responds urgently to everything. This includes not only cases where Ambulance and Police respond non-urgently (such as a 'concern for welfare' where

[11] Minutes of Sydney Joint Consultative Meeting (ASNSW & HSU) held on 5-6-08

there is no indication of any injury) but it also includes calls to automatic fire alarms, even when someone has called to confirm that there is no actual fire.

[following section omitted by secretariat to protect identity of author, as requested]

While I am the first to suggest that the NSWFB approach is dangerously overzealous, I believe that the ASNSW approach is putting patients at risk by not responding urgently as often as it should.

There is a serious problem if ambulances are sent non-urgently to any of the situations listed in the table above, while fire engines are running 'lights and sirens' to calls that they know are not time critical.

9. SUICIDE

I am aware of several officers who have committed suicide during their careers and I feel the number may be increasing.

[following 2 pages omitted by secretariat to protect identity of author, as requested]

I worked as a over a 16-year period and as a for 11 years. I have been a for 27 years and I can't think of one suicide among any of their workers. I would be very interested to know how the ASNSW suicide rate compares to other industries.

It is hard to know why anyone suicides. I imagine that the individuals would have deep-seated unresolved personal issues but our work must necessarily affect us. The ASNSW currently has a number of support mechanisms available to employees. These include

- Peer Support Officers – other ambos trained to offer a first level of support
- Chaplains – Religious practitioners of various faiths – all volunteers
- Employee Assistance Program – professional, confidential counselling through an external provider
- Group debriefing after major incidents - not all personnel are likely to attend and debriefing is rarely done, anyway, only after *very* major incidents
- District Officers (1 step above S/Os) are able to debrief ambos after smaller, traumatic incidents such as murders. Some occasionally take the opportunity to offer such proactive support, and it is very useful, but it is also rather brief as our Co-ordination Centre will be on the phone within an hour, pestering the crew/s to get back to work.

The ASNSW will boast that it supports staff by having these things in place. Unfortunately, most support systems go unused by the majority of ambos. The posters are on the walls and information is no doubt provided to us in various ways but there is no point in having support merely *available*. Support needs to be *offered* directly. A few D/Os and our local Chaplain are very good but it is usually up to the ambos themselves to ask for help. I suspect that the ones who ask for help are not necessarily the ones who need it the most.

For comparison, I believe that train drivers who have someone jump in front of their train automatically get three weeks off – immediately – with no loss of sick leave. They are given a counselling programme and possibly other support. They rarely even have to view the body lying under their train, let alone touch it.

I believe that fire-fighters who happen to encounter a deceased person at a fire also get time off and automatic counselling. They also rarely have to handle a body or deal with relatives.

Ambos, however, deal with dead and dying people every week, sometimes several in one shift. We have all lost count of the deaths and horrific injuries we have handled and, unlike firefighters or train drivers, we not only have to manage the deceased person but also support the shocked bystanders and grieving relatives.

Naturally, ambos do support each other with informal chats but the ASNSW basically ignores the need to do anything more than this.

The NSW Police Force has experienced a high number of suicides. I am aware that it has a "Traumatic Incident Database" to collect names of officers as they attend various unpleasant incidents. This tool is used to identify those who might need some support.

If our work bothers us, we have to use our sick leave to have time off. My main point is that it is up to us to request the leave or the support.

I suppose that if ambos were offered the sort of leave and counselling provisions that are given freely to other workers, then the Health system would crumble because no ambos would be at work.

I can only speculate that the cumulative effect of Post Traumatic Stress Disorder is manifesting itself in the suicide rate within our Service because of the lack of interest or understanding by the current senior ASNSW management.

OTHER COMMENTS

FIRST RESPONSE MEDICAL

There has been talk in the media that the NSWFB is attending a significant number of cases in a first aid capacity, and this is because the ASNSW's resources are so stretched. One article mentioned that the NSWFB attended over 5000 'medical' cases last year but, reading further, it clarified that less than a tenth of that number were truly for a first aid role. The formal 'first response' programme that has been set up in some rural areas would account for many of these.

The NSWFB collects its own figures on many things. I have been told by those who know the NSWFB that every time a fire-fighter helps an ambo to hold a stretcher, it gets recorded as them giving "medical assistance". I am most suspicious of any NSWFB figures that have not been independently verified.

The reason some fire-fighters are suggesting that the NSWFB takes on a First Response Medical role is that they would all require extra training and therefore be able to demand a pay increase.

In about 1994, the Melbourne Ambulance Service (MAS) was decimated through a privatization experiment that went horribly wrong. Having moved much of the service to private companies, which were then contracted to do only routine work, the reduced number of emergency crews was insufficient to cope with the emergency workload. Response times blew out and people died.

A quick-fix was to involve the Melbourne Fire Brigade in 'first responses' to serious medical calls. Fire-fighters were trained to use oxygen and semi-automatic defibrillators and were sent to anything that sounded like a cardiac arrest. They all got a pay rise for the extra responsibility.

A few years later, the MAS was improved and, although the first response system is still in place, the need for it has reduced considerably. The fire-fighters, naturally, kept their pay rise.

CONCLUSION

The more I write, the more issues keep springing to mind. I have evidence to support most of my statements, however some of my comments are, admittedly, merely opinion. If my observations and experiences are of interest to the inquiry, I would make myself available to provide further written or verbal input.

I am totally committed to my patients and very loyal to the Ambulance Service as an entity that serves them. I have enormous respect for some managers in the Service but I am not loyal to those executives and managers who do not treat people fairly, or with openness and honesty.

I hope the Inquiry team's first recommendation will be that the ASNSW returns to a uniformed hierarchy that has a fundamental knowledge of ambulance work and a genuine commitment to meeting the needs of the community.

The installation of a uniformed Ambulance Commissioner would go a long way towards improving morale and accountability for executive level decisions.

Appendices A & B are found as separate files attachments when this document is e-mailed

Appendix C ASNSW - Comparison to Other Agencies

It seems to go unnoticed that society is prepared to fund a fire service twice the size of the ambulance service despite the fact that the NSWFB has a small fraction of our workload and does not even serve the whole of NSW as the Ambulance Service does.

The Fire Brigade owns its buildings, owns its vehicles and proactively demands more money in order to provide a level of coverage that ensures that, 90% of the time, the entire service is doing nothing more than being available.

Comparing this to the ASNSW, we see that an operational review in 2001 found that the ASNSW is overloaded from 0700 to midnight and slightly less busy between midnight and 0700. In response to this, staffing numbers at night were reduced in order "to better match the workload".

In other words, firefighters spend perhaps 90% of their shifts inactive and this is considered acceptable, yet if ambulance officers get just 10% downtime, then something is wrong and we must get them out working harder! These figures are, of course, merely my estimates but they are honest estimates. There are a great many A/Os whose working lives are spent doing case after case from the beginning of their shift to the end. They rarely get a meal break and often finish on overtime. Their pay packets are fairly good because of penalties, but they earn them.

A very few rural ambulance stations have a low workload but they are very much the exception to the rule. The workload of our quietest ambulance stations would be on par with the average fire station's workload. If there is a busy fire station somewhere, no one has told me about it!

The NSWFB uses a model of urban development and travel times to flag when it is time to move into a developing area. Once the data shows that a fire station is needed, local and State governments approve the construction of a station and firefighters take over from Rural Fire Service volunteers.

I should point out that I quite like the fact that firefighters spend time on station, waiting or training in case my house catches fire. It would just be nice if ambulances were equally on stand by in case I get chest pain.

As long ago as 1968, the Service planned to add a station at Carlingford/Pennant Hills, and 1975 saw plans for a station at Berowra. Service owned vacant land at Carlingford and was looking at property in the new areas around Dural. None of these stations eventuated. Ambulance Managers of the past saw that new stations would be needed in these growing areas. More recent "asset managers" simply sell Ambulance property and, today, there is a huge gap in ambulance services in Sydney's northwest.

In the 10 years, 1995 to 2005, the Melbourne Ambulance Service opened no less than 50 new ambulance stations. In the same period, the ASNSW opened just one new station in Sydney (Avalon). No additional Sydney Ambulance stations have been opened in the subsequent years either and there appear to be no plans to do so in the short, medium or long term.

This approach to service provision would not be tolerated by the Fire Brigades or Police.

[following 4 page appendix omitted by secretariat on request of author]